Reset Form

MassHealth

Division of Medical Assistance

Documentation of Need for Durable Medical Equipment and Supplies General Prescription Form

The information in Sections One, Two, Three, and Four must be completed by the servicing provider.

Section One

Member name: MassHealth no.:

Address:

Date of birth: Sex: Height: Weight:

Diagnosis:

ICD-9 code:

Section Two

Prescriber name: Tel. no.:

Address:

UPIN no.:

Section Three

Supplier name: Tel. no.:

Address:

Provider no.:

Section Four

Requested item(s) (use attachment if necessary): Service code(s):

1)

2)

3)

4)

THE FOLLOWING **MUST** BE COMPLETED BY THE PRESCRIBER OR A MEMBER OF THE PRESCRIBER'S STAFF.

Section Five

Length of need (no. of months: 1-99 [99 = lifetime]): 1) 2) 3) 4)

Medical justification for requested item(s):

Location in which member will customarily use item(s): ☐ home ☐ work ☐ other (please specify):

Section Six

Prescriber's Attestation and Signature/Date

I certify that I am the treating prescriber identified in Section Two of this form. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true and accurate and complete, to the best of my knowledge, and I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein (signature and date stamp not acceptable).

Prescriber's signature Date